

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00405

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert 412</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drumkirk</u> c. LENGTH OF STAY IN 1b <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MD</u>		2. USUAL RESIDENCE Where deceased lived. If institution: Residence before admission a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MD</u> d. STREET ADDRESS <u>MD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Eva Mae</u> First <u>Brady</u> Middle <u>Brady</u> Last <u>Brady</u> 4. DATE OF DEATH Month <u>1</u> Day <u>11</u> Year <u>1959</u>		5. SEX <u>7</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 27, 1914</u> 9. AGE (In years last birthday) <u>44</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>MD</u> 11. BIRTHPLACE (State or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Thomas H. Crumpler</u> 14. MOTHER'S MAIDEN NAME <u>Bertha Wetzig</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>319-42-4189</u> 17. INFORMANT <u>Brady</u> Address: <u>Drumkirk, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Body found in bed by husband about 11:50 PM</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Probably murder</u>		20c. TIME OF INJURY Month, Day, Year Hour <u>11</u> o. m. <u>10</u> p. m. <u>59</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Drumkirk</u> (County) <u>Calvert</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u> EXAMINER'S NAME (Type) <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>Jan. 14 1959</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u> 22d. LOCATION (City, town, or county) <u>Lothian</u> (State) <u>Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>Drumkirk MD</u>		24a. REC'D BY REGISTRAR <u>JAN 14 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur E. Thomas</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

.....
[Signature]

Found in bed by
[Signature]
PC 110

1/10/11

00406

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

423 CERTIFICATE OF DEATH

Reg. Dist. No. 57

1. PLACE OF DEATH COUNTY <u>County Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown, Maryland.</u>	
TOWN <u>Huntingtown</u>		TOWN <u>Huntingtown, Maryland.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home; Huntingtown, Md.</u>		STREET ADDRESS <u>same as above</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Preston</u> (First) <u>-</u> (Middle) <u>Brown</u> (Last)		4. DATE OF DEATH <u>Jan</u> (Month) <u>31</u> (Day) <u>1959</u> (Year)	
5. SEX <u>m</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE (MARRIED) WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>4/12/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer and Custodian</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>70</u> yrs. If under 1 year Month Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Calvert County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gilbert Henson</u>		14. MOTHER'S MAIDEN NAME <u>Nettie Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Mattie Kyler-Huntingtown, Md.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebral accident

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive C.V.R. disease

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☐

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-10, 1955, to 31 Jan, 1959, that I last saw the deceasedalive on 31 Jan, 1959, and that death occurred at 11 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)

DATE THEREOF 2/3/59NAME OF CEMETERY OR CREMATORY Carrolls Church Cem.LOCATION (City, town, or county) Barstow, Cal. Co., Md.

(State)

DATE REC'D BY LOCAL REG. 2-3-59

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB 4 '59

Arthur L. Huns

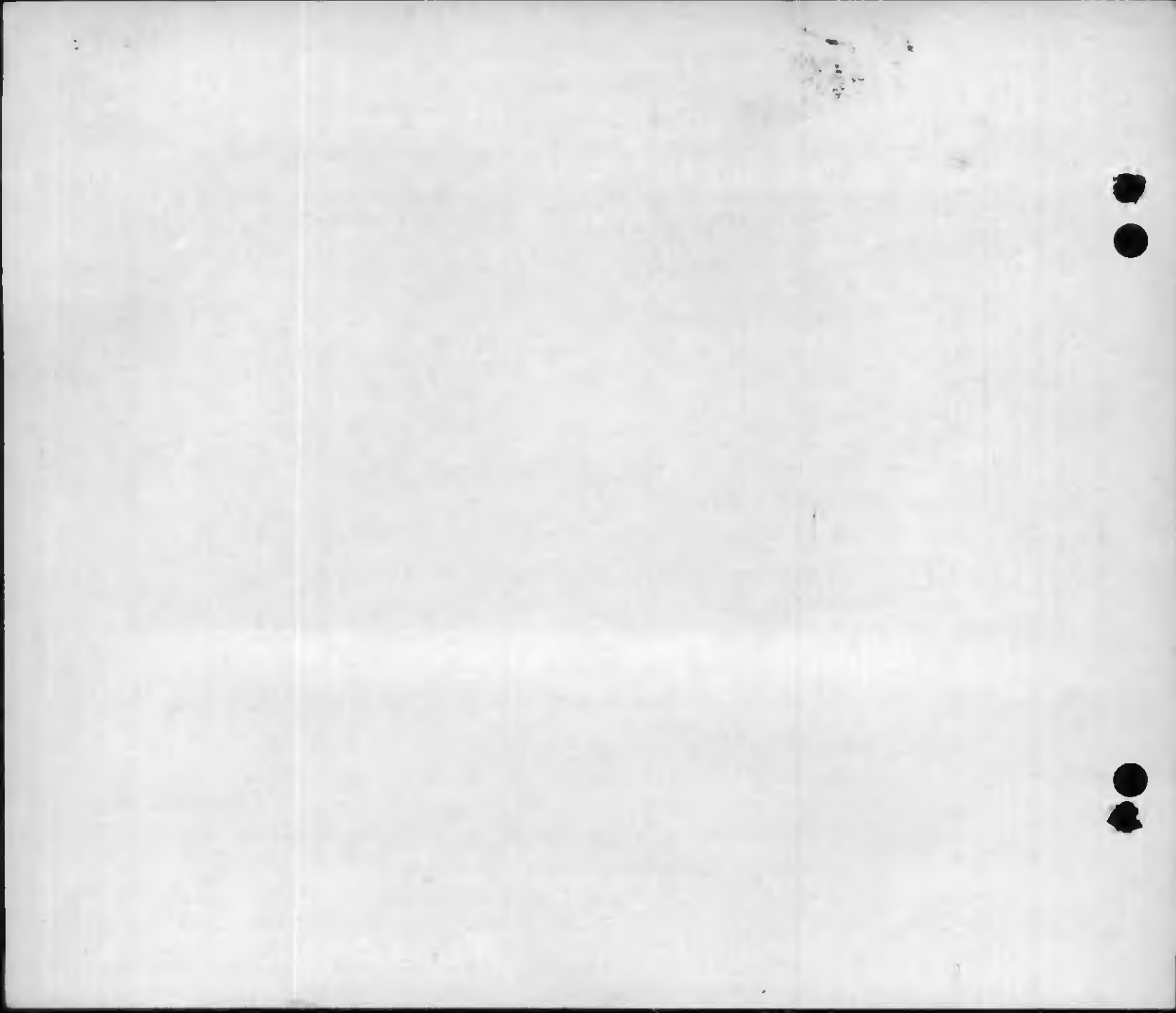
(M.P.)

LEROY E. BERRY

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00407

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE where deceased lived. If institution, residence before admission a. STATE <u>MD</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Georges</u>		c. LENGTH OF STAY IN 1b <u>10 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ches. Beach Ind</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co Hospital</u>				d. STREET ADDRESS <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Loye</u> Middle <u>G.</u> Last <u>Bulter</u>				4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/6/1918</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Foreman</u>		11. BIRTHPLACE (State or foreign country) <u>Conn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Bulter</u>				14. MOTHER'S MAIDEN NAME <u>Charlotte Balch</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, for unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WN#</u>		17. INFORMANT <u>Burton Bulter - Chesapeake Beach, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Embolism</u> <u>977X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fracturing of both arms</u> DUE TO (c) <u>Self inflicted</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fund bleeding in brain & heart 11/14/59 at 5 AM</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED, giving nature of injury in Part I or Part II of item 18.) <u>Self inflicted</u>					
20c. TIME OF INJURY Month, Day, Year <u>Nov 11/2 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Ches. Beach Cabot MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 16, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington Va</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Wackness & Son - Mutual, Ind</u>				24a. REC'D BY REGISTRAR <u>JAN 16 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Manner of Death: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

RECEIVED
STATE DEPARTMENT OF HEALTH
JAN 10 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

415

CERTIFICATE OF DEATH

Reg. Dist. No.

00408

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Owings</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Curtis</u> Last				4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 15, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wallace</u>				14. MOTHER'S MAIDEN NAME <u>Aire Adams</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Savonia Jacks, Owings, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Cerebral sclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 23, 1958</u> to <u>Jan 1, 1959</u> that I last saw the deceased alive on <u>Jan 1, 1959</u> and that death occurred at <u>St Leonard</u> , Md. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>1/3/59</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				PHYSICIAN'S NAME (Type) <u>Dr. Roberto de Villarreal</u> <u>St. Leonard, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan 4, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		22d. LOCATION (City, town, or county) (State) <u>Sundeland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Fred, Md</u>				24a. REC'D BY REGISTRAR <u>JAN 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

416 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Anne Arundel</u>		c. LENGTH OF STAY IN 1b <u>Not applicable</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. Hospital</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>Minnie L. Perry</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/20/54/1872</u>
9. AGE (In years, months, days) <u>54</u> yrs. <u>11</u> months <u>8</u> days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H W</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Lucille</u>		14. MOTHER'S MAIDEN NAME <u>Ann Hedrick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Benny Lucille, Pat Rydman</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition</u> <u>900.0</u> DUE TO <u>Fractured legs</u> Conditions, if any, which gave rise to immediate cause (b) <u>3 Ws</u> (c) <u>3 Ws</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fell down stairs at home</u>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down stairs at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>10/2</u> p. m. <u>58</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY OR TOWN (County) (State) <u>Port Republic Calvert Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>A G. Hardness & Son</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>1/24/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried Jan 10-1959</u>		22b. DATE THEREOF <u>Jan 10-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Port Republic - Calvert Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A G. Hardness & Son</u>		24a. REC'D BY REGISTRAR <u>JAN 28 '59</u>	
ADDRESS <u>Mulberry, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Hearn</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

REPLACEMENT: Film 238 - 1-28-59 ams

417

CERTIFICATE OF DEATH

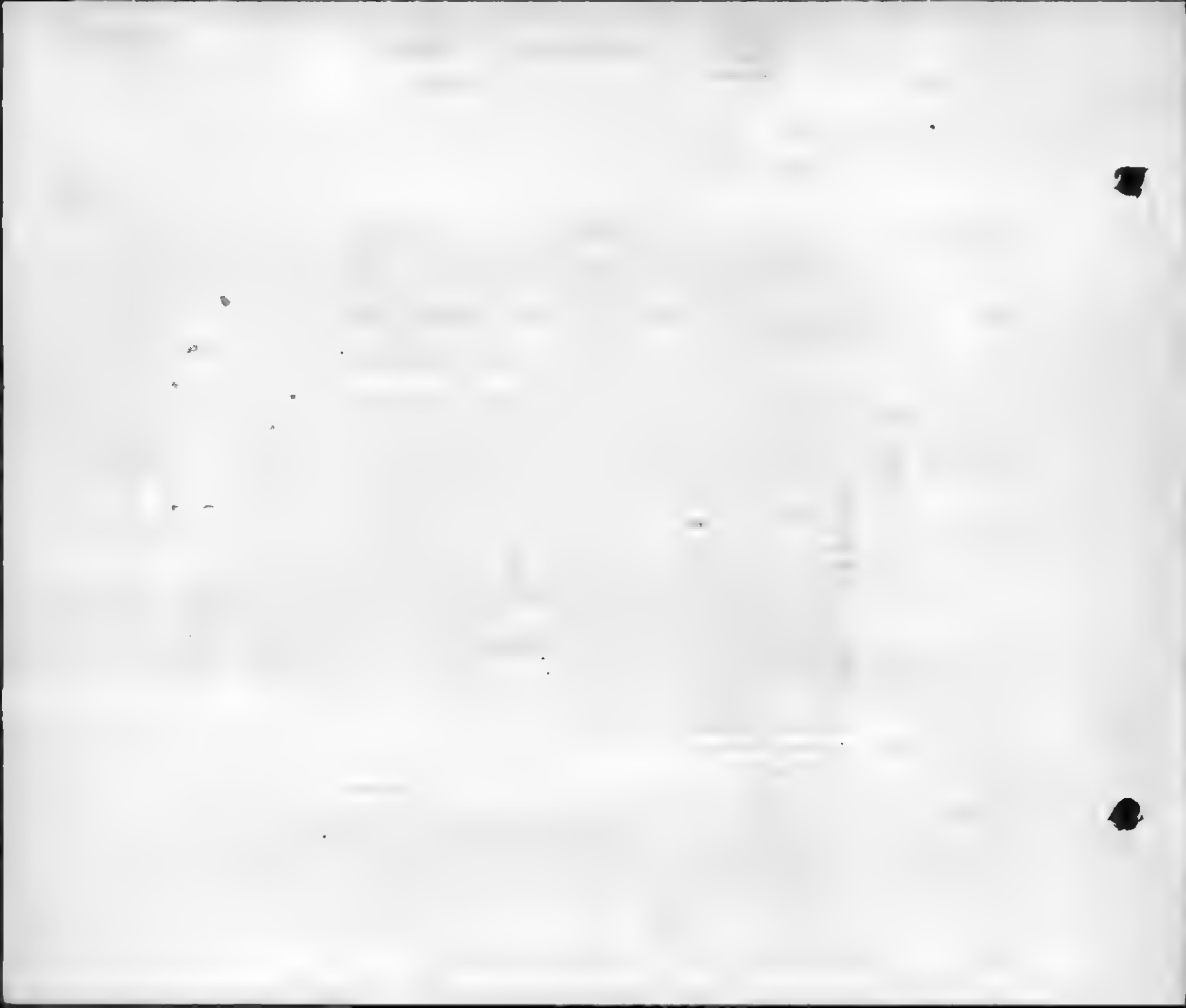
00410

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Cabot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Huntingtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <u>Arthur P. Gibson</u>				4. DATE OF DEATH Month <u>Jan.</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1882</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Huntingtown, Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Gibson</u>				14. MOTHER'S MAIDEN NAME <u>Annie Mary Shuckillo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service) <u>220</u>		16. SOCIAL SECURITY NO <u>216-38-6418</u>		17. INFORMANT <u>Alvora Gibson - Huntingtown - Cabot Co., Ind.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of Aorta</u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>14 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Nov 1957</u> to <u>January 1959</u> , that I last saw the deceased alive on <u>Jan 23</u> 1959, and that death occurred at <u>100 M</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Page C. Jett</u>				ADDRESS (Street, city or town, state)		DATE SIGNED <u>1/24/59</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>				M. D. <u>PRIME FREDERICK</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county), (State)	
<u>Burial</u>		<u>Jan 25, 1959</u>		<u>Huntingtown Methodist</u>		<u>Huntingtown - Cabot Co - Ind -</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. C. Harkness & Son - Mutual, Ind.</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. Harkness</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

418

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>None</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Joseph</u> First <u>Richard</u> Middle <u>Edward</u> Last				4. DATE OF DEATH Month <u>1</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>?</u>	9. AGE (In years last birthday) <u>50</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph</u>				14. MOTHER'S MAIDEN NAME <u>Hall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Edward Hall</u> Address <u>Downing</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>442X</u> DUE TO <u>Acute vascular condition</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. [Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-1, 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Edmonson</u>		22d. LOCATION (City, town, or county) (State) <u>Sunderland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u>				24a. REC'D BY REGISTRAR <u>Dr. Fred. [Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



419

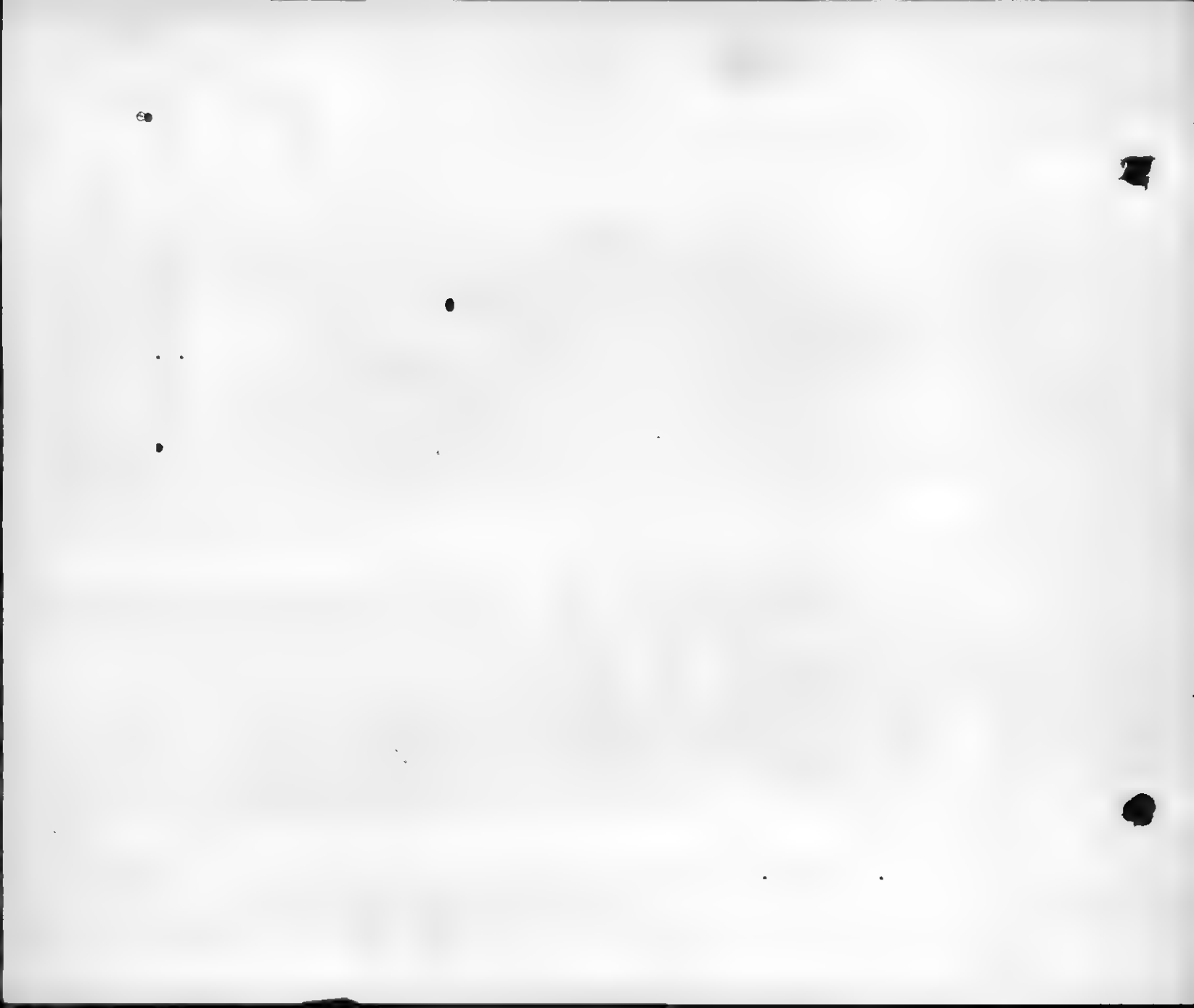
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Calvert b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick c. LENGTH OF STAY IN 1b Calvert County Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Calvert c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake Beach d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clyde Middle E. Last Jones		4. DATE OF DEATH Month January Day 25 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/02
9. AGE (In years last birthday) 56 yrs.		10. USUA: OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Jones		14. MOTHER'S MAIDEN NAME Maude E. Jordan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 579-12-5134	
17. INFORMANT Margaret K. Hines, Chesapeake Beach Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V.R. disease 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/29 , 19 58 , to 1/25 , 19 59 , that I last saw the deceased alive on 12/24 , 19 59 , and that death occurred at 5:15AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) Huntingtown, Maryland DATE SIGNED 1/25/59			
ACTUAL SIGNATURE Dr. George J. Weems		M.D. Huntingtown, Maryland	
PHYSICIAN'S NAME (Type) Dr. George J. Weems			
22a. BURIAL, CREMATON, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	1-27-59	Mt Harmony	Nr Owings Md.
23. FUNERAL DIRECTOR'S SIGNATURE Hutchins Funeral Home Owings Md.		ADDRESS	
24a. REC'D BY REGISTRAR Jan 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



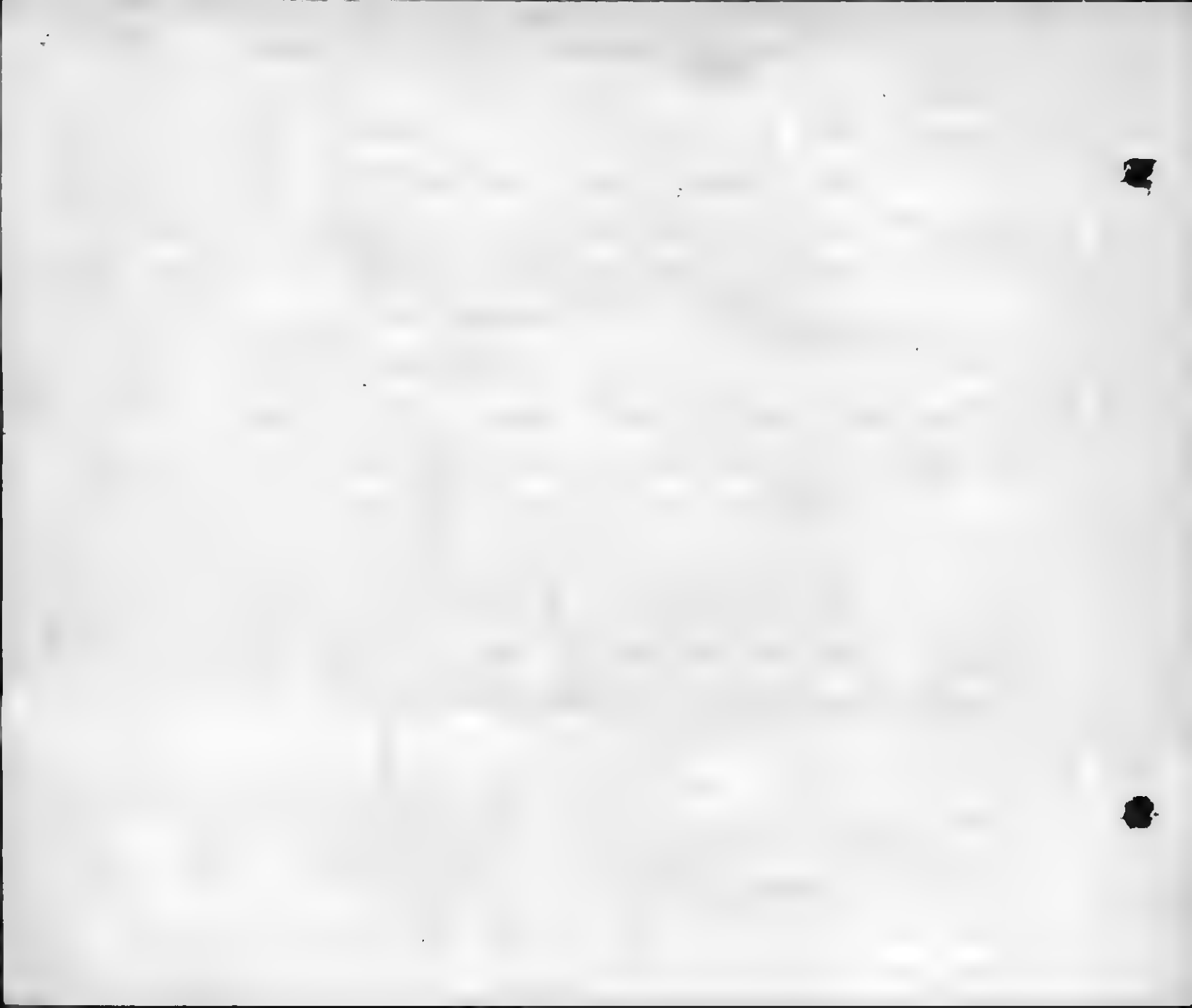
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00413

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Beach</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Johny</u> Middle <u>M.</u> Last <u>Kirin</u>				4. DATE OF DEATH Month <u>1</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 9, 1886</u>	9. AGE (In years - when birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel mill worker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Yugoslavia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Kirin '67-03-61198</u>				14. MOTHER'S M maiden name <u>Dobrinovic</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>X-167-03-61198</u>		17. INFORMANT <u>John P. Kirin N. Beach Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause pertinent for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular Renal Disease</u> <u>442X</u> DUE TO (b) <u>Age</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> <u>Found dead 1220 PM. 11/7/59</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H. W. Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>H. W. WARD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-9-59</u>		<u>Mount Carmel</u>		<u>Upper Marlboro Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings Md</u>				24a. REC'D BY REGISTRAR DATE <u>JAN 9 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



421

CERTIFICATE OF DEATH

00414

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabaret</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cabaret</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince-Frederick</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabaret County Hospital</i>				d. STREET ADDRESS <i>—</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Fred</i> Middle <i>K.</i> Last <i>Lankford</i>				4. DATE OF DEATH Month <i>Jan.</i> Day <i>7</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 12, 1901</i>		9. AGE (In years last birthday) <i>57</i> yrs.	IF UNDER 1 YEAR Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>	IF UNDER 24 HRS Months <i>—</i> Days <i>—</i> Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Pipes Fitter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Plumbing</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fred K. Lankford</i>				14. MOTHER'S M maiden NAME <i>Olivia Gaudin</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-16-3045</i>		17. INFORMANT <i>Amy Lankford - Solomons, Md.</i>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> <i>593X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive heart</i> DUE TO (c) <i>23 minutes</i>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>Jan 5</i> , 19 <i>59</i> , to <i>Jan 7</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>Jan 7</i> , 19 <i>59</i> , and that death occurred at <i>2:47</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Rdc Villapree</i> M.D.				ADDRESS (Street, city or town, state) <i>St Thomas</i> DATE SIGNED <i>1/7/59</i>			
PHYSICIAN'S NAME (Type) <i>Rdc Villapree</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 10, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Solomons Catholic Cem. Solomons - Cabaret Co - Md</i>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A J. Harkness & Son - Mutual, Md</i> ADDRESS				24a. REC'D BY REGISTRAR <i>DATE JAN 12 1959</i>		24b. REGISTRAR'S SIGNATURE <i>S. Harkness</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



422

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabret</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabret</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cabret County Hospital</u>		e. STREET ADDRESS <u>Barstow</u>	
3. NAME OF DECEASED (Type or print) First <u>Dorothy</u> Middle <u>Hall</u> Last <u>Syons</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>18</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 5 1904</u>
9. AGE (In years last birthday) <u>54</u> yrs		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u> Hours <u>19</u> Min <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabret Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Henry Hall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Felia Howard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Samuel L. Syons - Barstow, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Hypertensive (C.V. disease)</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u>			
(c) <u>Thrombosis of the coronary artery</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan. 18, 1959</u> to <u>Jan. 18, 1959</u> , that I last saw the deceased alive on <u>Jan. 18, 1959</u> , and that death occurred at <u>Md.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>[Signature]</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 20, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Miranda Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Cabret Co. - Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>G. A. Harkness & Son - Mutual, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 21 1959</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



423

CERTIFICATE OF DEATH

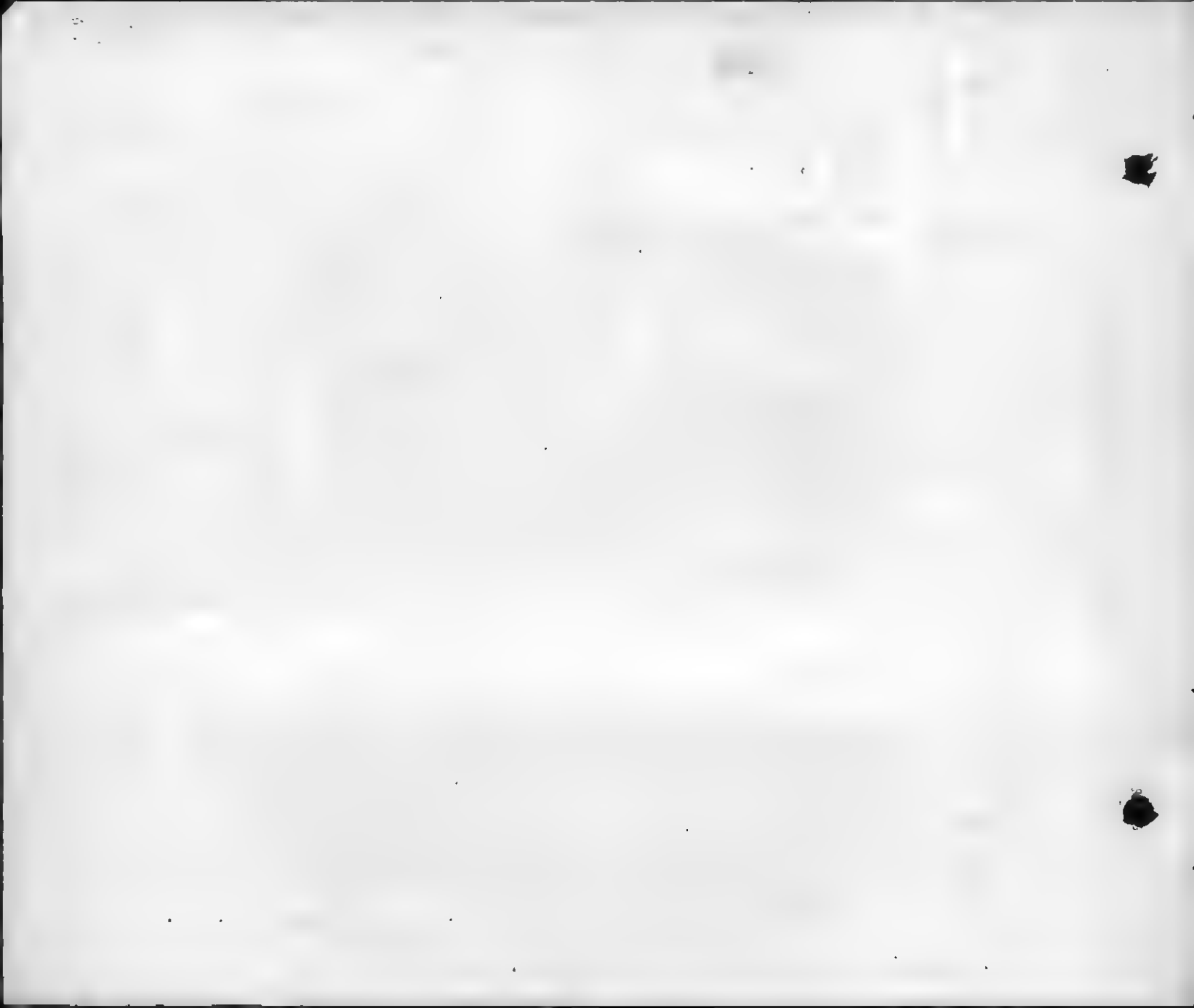
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Prince Frederick</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wash 19 D.C.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert Nursing Home</i>		d. STREET ADDRESS <i>62-63 T. Totole Rd</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>NEZ MARIE MORTON</i>		4. DATE OF DEATH / Month Day Year <i>1 10 1959</i>	
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1888-?</i>
9. AGE (In years last birthday) <i>70</i> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Washington D.C.</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Calvert Nursing Home Prince Frederick Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i>			
331X DUE TO			
(b) <i>HYPERTENSION</i>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis (Hypertension)</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour q. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 18, 1958</i> to <i>Jan 10, 1959</i> , that I last saw the deceased alive on <i>Jan 7, 1959</i> , and that death occurred at <i>7:15 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>James E. Pett</i>		DATE SIGNED <i>1/14/59</i>	
PHYSICIAN'S NAME (Type) <i>PAUL C. PETT</i>		ADDRESS (Street, city or town, state) <i>Prince Frederick Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>	22b. DATE THEREOF <i>1/12/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Port Lincoln Crematory</i>	22d. LOCATION (City, town, or county) (State) <i>Colmar Manor, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>		ADDRESS <i>Hyattsville Maryland.</i>	
24a. REC'D BY REGISTRAR <i>JAN 14 '59</i>		24b. REGISTRAR'S SIGNATURE <i>William E. Thomas</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



424

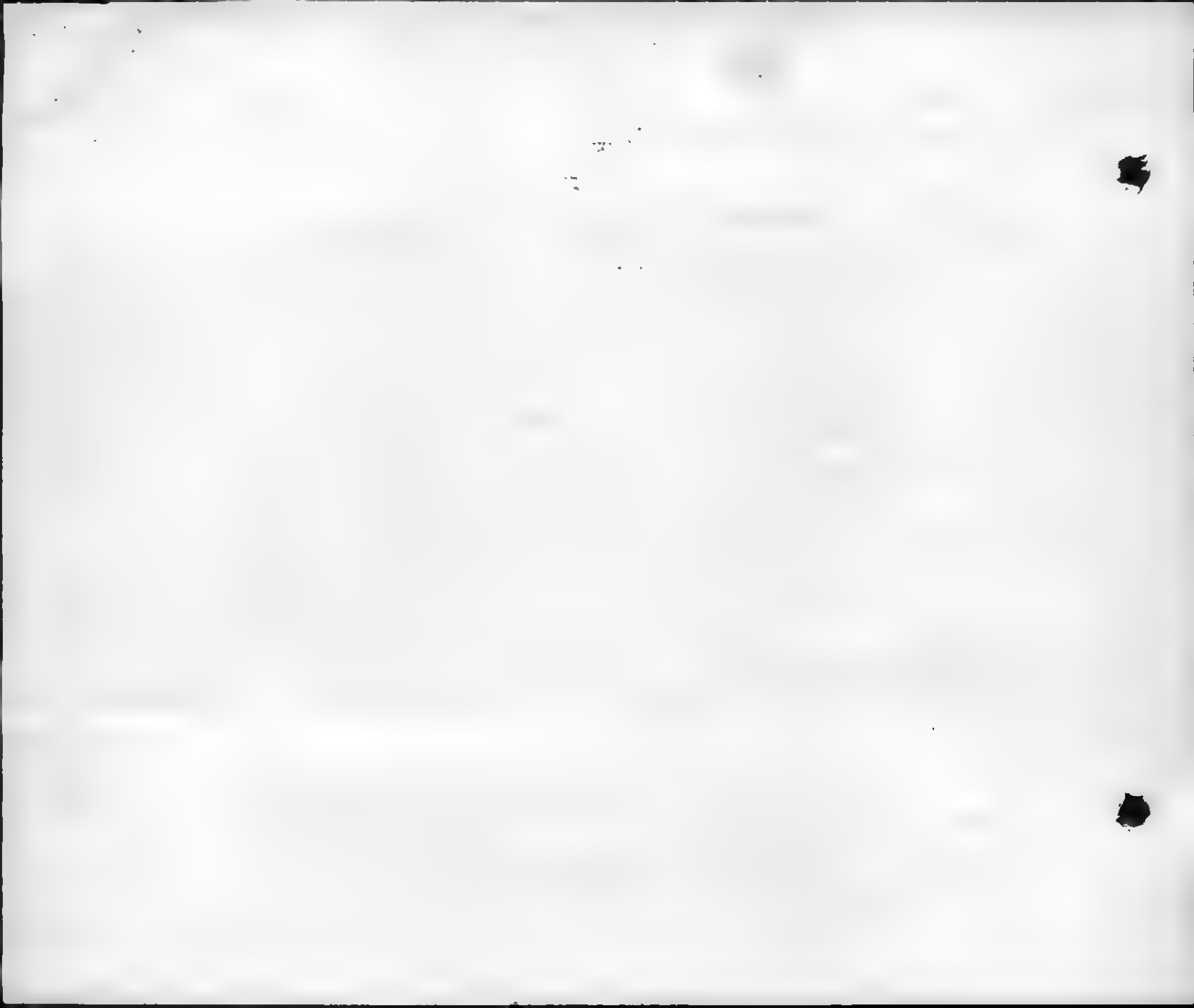
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>B. A. C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>3 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>		d. STREET ADDRESS <u>hottian</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick</u> First <u>William</u> Middle <u>Scribner</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-15-1871</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patrol</u>		9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min
10b. KIND OF BUSINESS OR INDUSTRY <u>Patrol</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13. FATHER'S NAME <u>William B. Scribner</u>		14. MOTHER'S MAIDEN NAME <u>Sally Barber</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Annie B. Scribner</u> Address <u>hottian Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chronic Arteriosclerosis (Nephrosclerosis)</u> DUE TO (c) <u>Dehydrated Myocardium</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1/15</u> 19 <u>59</u> to <u>1/13</u> 19 <u>59</u> , that I last saw the deceased alive on <u>1/12</u> 19 <u>59</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>George Jett</u> M.D. <u>PRINCE FREDERICK</u> PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u> <u>Prince Frederick</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>Jan 15 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>	22d. LOCATION (City, town, or county) (State) <u>Trappe, Maryland</u> <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James A. Jett</u>		ADDRESS	24a. REC'D BY REGISTRAR DATE <u>JAN 16 59</u>
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



425

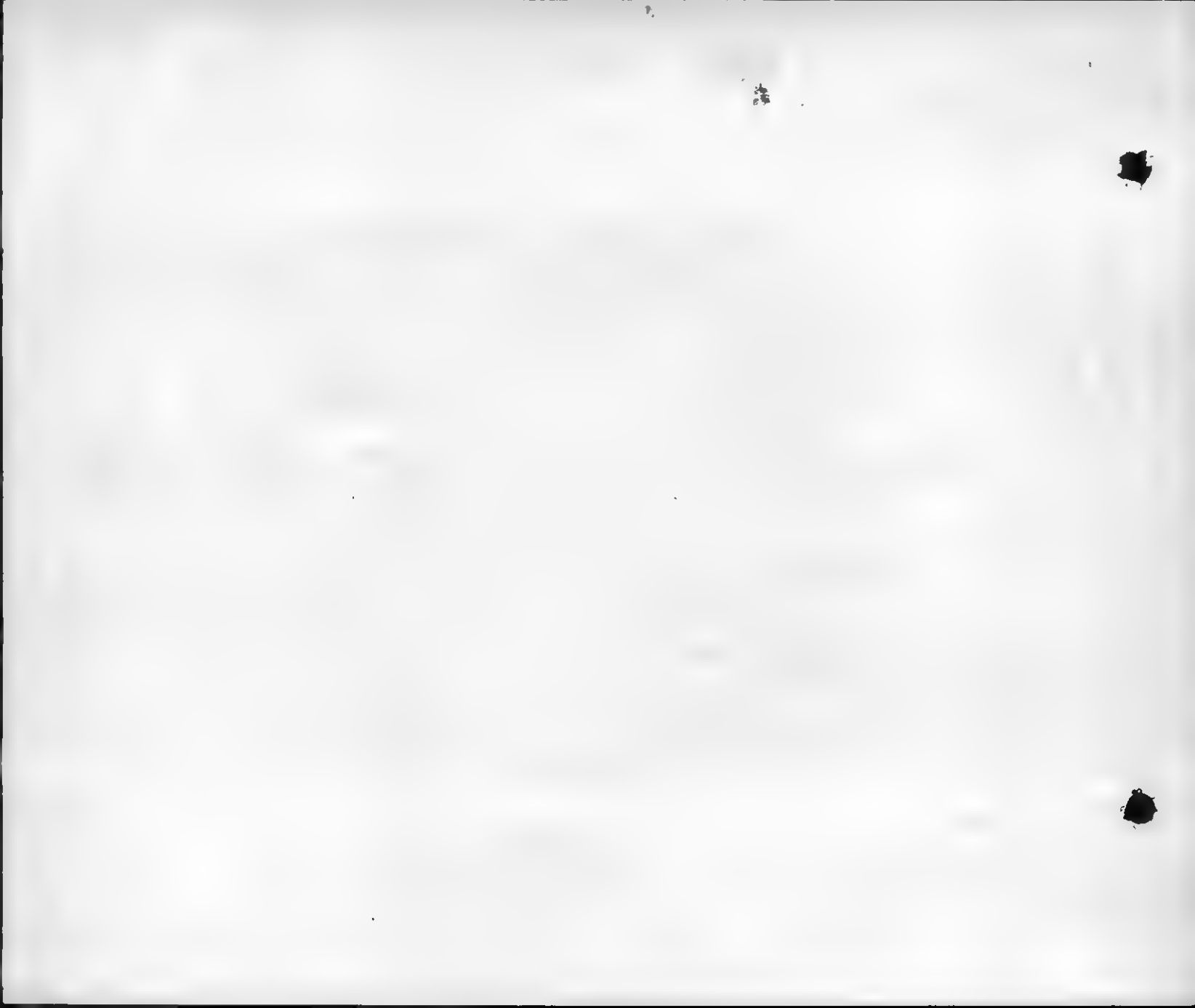
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabaret</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Prine Frederick</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION <u>Cabaret County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cabaret</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bartow</u> d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Susan Rebecca Stafford</u> First Middle Last		4. DATE OF DEATH <u>Jan. 24 1959</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13, 1875</u> 9. AGE (in years last birthday) yrs. <u>83</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cabaret Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Augusta Tucker</u>		14. MOTHER'S MAIDEN NAME <u>Annie White</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO <u>220</u>	
17. INFORMANT <u>Frank Stafford - Bartow, Ind</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart failure (coronary thrombosis)</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Intestinal obstruction.</u> DUE TO (c) <u>3 previous intestinal surgery</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 21, 1959</u> to <u>Jan 24, 1959</u> , that I last saw the deceased alive on <u>Jan 24, 1959</u> , and that death occurred at <u>9:51</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.		ADDRESS (Street, city or town, state) <u>514 Leonard St</u> DATE SIGNED <u>1/24/59</u>	
PHYSICIAN'S NAME (Type) <u>R. DETMERS</u>		<u>St Leonard</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Jan 27, 1959</u>	<u>Osborn Cemetery</u>	<u>Bartow - Cabaret Co - Ind.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>O. G. Harkness & Son - Bartow, Ind</u>		24a. REC'D BY REGISTRAR <u>Jan 27 59</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Calvert Co.</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>1 years.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Nursing Home.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryantown</u>	
3 NAME OF DECEASED (Type or print) <u>Edward</u> First Middle Last <u>TURNER</u>		4. DATE OF DEATH <u>Jan.</u> Month <u>15</u> Day <u>1959</u> Year	
5 SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 11, 1876</u>
9. AGE (In years last birthday) <u>82 yrs</u>		IF UNDER 1 YEAR	IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Newspaper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry A. Turner</u>	
14. MOTHER'S MAIDEN NAME <u>Marguerite A.</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John T. Mudd, Bryantown, Md.</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 minutes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>Dec 19, 1958</u> to <u>Jan 13, 1959</u> that I last saw the deceased alive on <u>Jan 18, 1959</u> and that death occurred at <u>6 p.</u> M, from the causes and on the date stated above			
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>[Signature]</u>		DATE SIGNED <u>Jan 20 1959</u>	
PHYSICIAN'S NAME (Type) <u>PAGE C. JETT</u>		<u>PRINCE FREDERICK</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>January 18, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	22d. LOCATION (City, town, or county) (State) <u>Waldorf Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Huntt Funeral Home, Waldorf, Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>JAN 20 59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The registrant must remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										00421
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No.
1. PLACE OF DEATH a. COUNTY Calvert MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Calvert					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Paris			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dunkirk				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS 1					
3. NAME OF DECEASED (Type or print) Phillip ODELL First WILSON Last					4. DATE OF DEATH Month January Day 19 Year 1959					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 28,		9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm laborer					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Roland Ler Wilson					14. MOTHER'S MAIDEN NAME Sadie Young, Dunkirk Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. 579-01-9635		17. INFORMANT Sarah Wilson Dunkirk, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Exposure 932.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Alcoholism DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Exposure to cold					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 1/18/1959			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) Paris		20g. (County) (State) Calvert Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE William V. Lovitt, Jr.					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED 1/20/59		
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.					ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) 1-22,59			22b. DATE THEREOF Coopers			22c. NAME OF CEMETERY OR CREMATORY Halle Creek, Md			22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE P.E. Sewell Prince Fred, Md					24a. REC'D BY REGISTRAR DATE JAN 26 '59			24b. REGISTRAR'S SIGNATURE Arthur L. King		

STATE OF MARYLAND
JULY 1917

RECEIVED
JULY 1917
JULY 1917

MARYLAND STATE DEPARTMENT OF HEALTH - SANITARY
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1917

July 1917

Death

Age

Color

Place of Birth

Married

Occupation

Residence

DEATH CERTIFICATE

1. Name of Deceased	2. Sex	3. Age	4. Color
5. Place of Birth	6. Married	7. Occupation	8. Residence
9. Date of Death	10. Time of Death	11. Cause of Death	12. Signature of Medical Examiner
13. Signature of Physician	14. Signature of Coroner	15. Signature of Registrar	16. Signature of Burial Officer

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
429 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Adelphi</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Wm</i> First <i>Billy</i> Middle <i>Young</i> Last		4. DATE OF DEATH Month <i>1</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>E</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>4/20 1873</i>
9. AGE (In years, months, and days) <i>85</i> yrs.		10. IF UNDER 1 YEAR Months <i>11</i> Days <i>15</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Public Work</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>State Rd</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Robert Young</i>		14. MOTHER'S MAIDEN NAME <i>Esther Roberts</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <i>Nancy Young</i> Address <i>Adelphi Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure</i> <i>782.4</i> DUE TO <i>Age</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Age</i> (c) <i>Age</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been sick all day</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <i>a. m.</i> <i>p. m.</i> <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H W Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>1-8-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Carrolls</i>		22d. LOCATION (City, town, or county) (State) <i>Bearston Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. F. Sewell</i>		ADDRESS <i>Bruna Fredm</i>	
24a. REC'D BY REGISTRAR <i>1 2 59</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Kneel</i>	

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CERTIFICATE OF EXAMINATION

Name of Examinee		Date of Examination	
Age		Sex	
Place of Birth		Occupation	
Education		Previous Medical Examination	
Physical Examination		Mental Examination	
Diagnosis		Recommendation	
Signature of Examiner		Signature of Examinee	
Date of Issuance		Place of Issuance	

RECEIVED